PROVISIONAL PLAN OF CARE
CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE
MEDICAID WAIVER

State Form 51551 (3-04) / TS 0002

The information contained on this form is **CONFIDENTIAL** according to IC 16-39-2.

Name of recipient	Date of birth (*month, day, year*)	LOC approval date
Medicaid number (RID)	Date plan completed	
Address (*number and street, city, state, ZIP code*)		
Telephone number	Name of parent / guardian	

Presenting Problem: Describe problem and need for provisional plan of care.

Initial Plan:
Effective From: **To:**

Proposed Slot Number:

MEDICAID STATE PLAN AND WAIVER SERVICES	PROVIDER	TOTAL UNITS	COST PER UNIT	MONTHLY COST	TOTAL AMOUNT COST	START DATE	END DATE
Wraparound Facilitation							

Signature of parent / guardian	Date (*month, day, year*)
Signature of Wraparound Facilitator / CMHC	Date (*month, day, year*)